

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2018</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2501 DOWNING STREET SW WILSON, NC 27895</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000		
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately assess falls on a Minimum Data Set (a tool used for resident assessment) for 1 (Resident #1) of 3 sampled residents reviewed for falls. Findings included: Resident #1 was admitted to the facility 4/23/18. The latest Minimum Data Set (MDS) dated 4/27/18 and coded as a 5 day assessment revealed Resident #1 was cognitively intact, displayed physical behaviors directed towards others, and required extensive assistance for all activities of daily living (ADLs) except eating. Resident #1 was not steady for ambulation (walking) or transfers without staff assistance, had no limb impairments, and was frequently incontinent of bowel and bladder. Active diagnoses included muscle weakness, difficulty walking, and altered mental status. No falls prior to, or since admission were indicated on the MDS. A review of Resident #1's electronic medical record (EMR) revealed a user defined assessment (UDA) titled "Interdisciplinary Post Fall Review" dated 4/23/17. The post fall review revealed Resident #1 had a witnessed fall,</p>	F 641	<p>The Post fall review was missed by the MDS nurse as being completed in the Point Click Care system leading to the incorrect coding of the MDS for Resident #1</p> <p>The MDS assessment for Resident #1 was modified to code the fall as appropriate on 5-9-18 by the MDS Coordinator.</p> <p>An audit of all falls in the facility for the last 30 days was completed by the RCMD and MDS Coordinator to ensure the fall was captured on the MDS with modifications made as needed for any coding errors.</p> <p>Administrator educated MDS Department on coding falls on the MDS and reviewing all documentation in the Point Click Care system to indicate a resident had a fall. All falls are reviewed 5x week at morning meeting and are coded in the care management board for review.</p>	6/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  05/18/2018
--	-------	-----------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2501 DOWNING STREET SW</b> <b>WILSON, NC 27895</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 641	Continued From page 1 without injury, on 4/23/18 while being assisted to the commode. Further review of the EMR revealed Resident #1 had 2 additional falls on 4/27/18 at 2:27 AM and 4:03 AM. An interview was conducted with the MDS Coordinator on 5/9/18 at 12:40 PM. He stated his sources of information for the MDS were POC (Point of Care- the system used by nursing assistants to chart ADLs), hospital records, bedside assessments, family interviews, MARs (Medication Administration Records), TARs (Treatment Administration Records), user defined assessments-which included Interdisciplinary Post Fall Reviews, nursing notes, and therapy notes. He agreed the MDS dated 4/27/18 was incorrect and falls were not coded in the assessment. An interview was conducted on 5/9/18 at 12:43 PM with the Administrator. She agreed falls were not coded on the MDS dated 4/27/18 but should have been.	F 641	RCMD/MDS Coordinator will conduct random audits of three falls a week x 4 weeks then bi monthly for one month and then monthly x 1 month to ensure they were coded appropriately on the MDS utilizing an audit tool. The results of the audits will be brought through the monthly QAPI meeting for review and further suggestions monthly x 3 months.		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		6/6/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2501 DOWNING STREET SW</b> <b>WILSON, NC 27895</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 655	<p>Continued From page 2</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission with measureable objectives and timetables to address the immediate needs of 1 (Resident #1) of 3 sampled residents reviewed for falls. Findings included: Resident #1 was admitted to the facility 4/23/18. The latest MDS (Minimum Data Set-a tool used</p>	F 655	<p>The Point Click Care system does not alert staff when a new resident is entered into the system as being "due" because you have 48 hours to complete it so the nurse did not complete the baseline careplan for resident #1.</p> <p>The Baseline careplan was not completed for resident #1 as she had been</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2501 DOWNING STREET SW WILSON, NC 27895</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 655	Continued From page 3 for resident assessments) dated 4/27/18 and coded as a 5 day assessment revealed Resident #1 was cognitively intact, displayed physical behaviors directed towards others, and required extensive assistance for all activities of daily living (ADLs) except eating. Resident #1 was not steady for ambulation (walking) or transfers without staff assistance, had no limb impairments, and was frequently incontinent of bowel and bladder. Active diagnoses included muscle weakness, difficulty walking, and altered mental status. No falls prior to or since admission was indicated on the MDS. A review of Resident #1's electronic medical record (EMR) revealed an assessment titled "Interdisciplinary Post Fall Review" dated 4/23/17. The post fall review revealed Resident #1 had a witnessed fall, without injury, on 4/23/18 while being assisted to the commode. Further review of the EMR revealed Resident #1 had 2 additional falls on 4/27/18 at 2:27 AM and 4:03 AM. An interview was conducted with the MDS Coordinator on 5/9/18 at 12:40 PM. He stated his sources of information for the MDS were POC (Point of Care- the system used by nursing assistants to chart ADLs), hospital records, bedside assessments, family interviews, MARs (Medication Administration Records), TARs (Treatment Administration Records), User Defined Assessments-which included Interdisciplinary Post Fall Reviews, nursing notes and assessments, and therapy notes. He agreed the MDS dated 4/27/18 was incorrect and should have had falls included in the assessment. An interview was conducted on 5/9/18 at 12:43 PM with the Administrator. She agreed falls were not coded on the MDS dated 4/27/18 but should have been.	F 655	discharged from the facility at time of survey.  100% audit of all baseline careplans was conducted on 5-9-18 by SW and DON and no others were found out of compliance. All licensed nurses were educated on completion of the baseline careplan within 48 hours of admission and the fact that the Point Click Care system will not automatically generate the careplan and they must activate it on admission.  While reviewing new admissions into the computer system in morning meeting the facility will audit to ensure that the baseline careplan was completed. Any issues found during the morning review will be corrected by the nursing management team to include DON, SDC, ADON and MDS Department.  The Nursing Administration of the facility will audit two random new admissions weekly for 4 weeks and then bi-monthly x one month and then monthly x one month to ensure the baseline Careplan is completed.  The results of the reviews will be brought through the QAPI process monthly x 4 months for further review and recommendations.		